VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 21, 2016

Mr. Daniel Daly, Manager
The Residence At Shelburne Bay East
185 Pine Haven Shores Road
Shelburne, VT 05482-7805

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 14, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	06/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

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R100	Initial Comments: An unannounced onsite re-licensure survey was completed by the Vermont Division of Licensing and Protection from 6/13/16 - 6/14/16. The following regulatory violations were cited.	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that nursing needs related to care of respiratory treatment equipment was provided on a consistent basis for 3 of 3 applicable residents on one unit. (Residents #6, 11 and 12) Findings include: Per record review and observations (with facility staff) during the survey, three residents who utilized oxygen (O2) therapy and/or respiratory inhalation therapy did not receive routine cleaning and changing of lines utilized during therapies per observations and progress note reviews. During observations of the equipment for Resident #11, there was no date noted on the respiratory equipment (tubing) that required regular changing to assure it remained safe and sanitary for regular use. Nebulizer equipment that had been washed	R126	R126. For residents 6, 11, & 12 the oxygen tubing was immediately changed and labeled with the date. The mat was changed immediately. The Oxygen/Nebulizer Equipment policy was revised to include that oxygen tubing is changed at least monthly or more often if needed. Nebulizer's are cleaned after each use and tubing changes at least monthly. The revised policy in included. All Nurses and Med Techs will be in-serviced on revised policy by 7/19/16. Resident Care Director responsible for compliance.	7/19/16

R126 - R302 POC's accepted 7/20/16 MBolton RN/ PM

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R126	Continued From page 1 was seen stored on a drying mat next to the kitchenette sink; the mat had visible soiling. Per observation of O2 tubing for Resident #12, there was no date noted on the tubing to indicate a process of changing the tubing routinely to assure that the equipment was safe and sanitary. Per review of a progress note for Resident #6, the note read "staff reported that the resident's 02 tubing is very dirty and appears moldy". Per interview with the MT (medication technician) accompanying the surveyor for the observations, the MT confirmed that there was no procedure that s/he was aware of related to the care and changing of respiratory equipment. S/he stated that they do change the tubing if they look dirty, but s/he is not aware if any other staff do this. Per interview, the Interim DNS (Director of Nurses) confirmed that there was no policy/procedure to direct staff for the cleaning and changing of respiratory equipment at present.	R126		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that residents were	R135	R135. For residents 1 & 6 assessments are current. The community will run weekly overdue assessment report to ensure that all assessments are completed within required time line. All newly admitted residents will be assessed within 14 days of admission. All nurses will have in-service and training on timely assessment completion by 7/19/16. The Resident Care Director is responsible for compliance.	7/19/16

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R135	Continued From page 2 assessed by a licensed nurse within 14 days of admission to the home for 2 of 10 residents reviewed (Residents #1 and #6). Findings include: 1). Per record review, the admission assessment for Resident #1, who was admitted on 9/16/15, was not signed the the RN as completed until 3/12/16. The late assessment was confirmed during interview with the Interim DNS (Director of Nursing Services). 2). Per record review, the admission assessment for Resident #6 (admitted on 1/11/15) was not found in the medical record and per interview with the Interim DNS, s/he was not able to locate an admission assessment completed within 14 days of admission.	R135		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident was assessed at least annually for 4 of 10 residents in the applicable sample. (Residents #4, 6, 8, and 10). Findings include:	R136	R136. The community will run a report for overdue assessments on a regular basis. It is our policy that all residents are assessed annually and for significant changes in condition. All Nurses will have in-service on timely assessment completion by 7/19/16. The Resident Care Director is responsible for implementation of this policy/regulation. Resident Care Director responsible for compliance.	7/19

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R136	Continued From page 3 Per record reviews during the survey, 4 residents were not assessed at least annually (within 365 days). The following list includes the specific examples of non-compliance with this requirement. a. Resident #4, had a full assessment completed on 12/17/13, and there was no full assessment located for the year 2014. b. Resident #6 had a full assessment dated 5/27/14 and the next full assessment was completed on 3/12/16, a period greater than 365 days. c. Resident #8 had a full assessment on 5/17/14, with the next full assessment completed on 8/29/15, a period greater than 365 days. d. Resident #10's last full assessment was completed on 6/1/15. The annual assessment for 2016 had not been completed as of the date of survey (6/14/16), thus it was late. Additionally, the only other full assessment completed for this resident was dated 12/17/13; it was the admission assessment. The failure to conduct at least annual assessments (within 365 days) was confirmed during interview with the Interim DNS (Director of Nursing).	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;	R145	R145. Resident #6's care plan has been updated addressing the residents' needs related to oxygen therapy. All nurses will be in-serviced on Care Plans and updating plans based on resident needs by 7/19/16. Random audits conducted by RCD & RN's to ensure compliance RCD to ensure Compliance and Bring Results of Audits to quarterly QA Committee.	7/19/16

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R145	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the Nurse failed to assure that the care plan for 1 of 10 applicable residents in the sample addressed all of the residents care needs. (Resident #6). Findings include: Per record review, the care plan for Resident #6 did not address the resident's needs related to oxygen therapy. The provider ordered "02 at 2 liters/min. while ambulating, and 02 at 2 liters/min via nasal cannula if ambulating greater than 100 feet as resident allows." The resident was observed ambulating back to their room after the morning and noon meals in the unit dining room. The resident also has orders to "Keep the HOB (head of the bed) elevated at 45 degrees while in bed." Per review of the care plan, these needs related to oxygen therapy and maintenance of oxygen tubing/equipment, including a process to change out tubing were not addressed on the care plan. The failure to address these needs on the care plan was confirmed during interview with the Interim DNS.	R145		
R179 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to	R179	R179. It is the policy that direct care staff receive 12 hours of in servicing annually and upon hire and annually to include 7 required trainings. The yearly training calendar does include the required trainings. The 2016 Annual Calendar is included. The required in-service manual has been updated and the annual in-service calendar includes requirements. Periodically (at least	7/19/16

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R179	Continued From page 5 residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that staff completed the Vermont State required trainings for 2 of 5 staff in-service records reviewed. Findings include: Per review of a random sample of 5 staff in-service records, 2 of the 5 staff selected had not completed all 7 of the Vermont mandated trainings at least annually. The Administrator was able to show evidence that the 2 staff had attended some of the trainings, however, s/he stated that the records were incomplete and could not be located during the 2 days of survey.	R179	R179. Continued. twice per year) in-service attendance will be audited for direct care associates to insure in-service attendance. Associates will be notified if requirements are not met. It is the Resident Care Directors responsibility to ensure all regulations are followed. Executive Director to ensure compliance.	
R200 SS=O	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures	R200		

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R200	Continued From page 6 Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to develop a policy/procedure to govern all services provided by the home related to nursing care for 3 residents in the targeted sample. (Residents #6, #11 and #12). findings include: Per observations, staff interview and record review, there was no evidence of a process/policy to address the care and maintenance of 02 tubing and/or equipment used for delivery of respiratory medications via inhaled route (nebulizer treatments) for 3 second floor unit residents. For Residents #11 and 12, the equipment was observed in resident rooms accompanied by the MT (medication technician). The residents had oxygen therapy and/or Nebulizer treatments and equipment had no dates on the tubing in use to indicate a date to replace the tubing to assure clean and sanitary equipment. For Resident #6, a progress note dated 6/3/16 stated, "staff reported that the resident's 02 tubing is very dirty and appears moldy". During interview with the MT after the observations, s/he confirmed that they were not aware of any policy for scheduled times when respiratory tubing should be changed to assure clean and sanitary equipment. They also confirmed there was no schedule or procedure to direct staff in a process to clean the nebulizer equipment. The failure to develop a policy/procedure to	R200	R200. For residents 6, 11, & 12 the oxygen tubing was immediately changed and labeled with the date. The mat was changed immediately. The oxygen/Nebulizer Equipment policy was revised to include that oxygen tubing is changed at least monthly or more often if needed. Nebulizer's are cleaned after each use and tubing changes at least monthly. The revised policy is included. All Nurses and Med Techs will be in-service on revised policy by 7/19/16. Resident Care Director to monitor to ensure compliance.	7/19/16

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R200	Continued From page 7 address the use of oxygen equipment, including cleaning and changing of tubing was confirmed during interview with the Interim DNS.	R200		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that stored food was properly labeled and dated and/or discarded when outdated. Findings include: Per observation the large walk-in cooler in the Main kitchen which supplies food to the satellite kitchen at the facility, it contained food that was was unlabeled or beyond the discard date. There were two large serving pans. on a low shelf to the left of the door, containing food and covered by saran wrap which were not tabled as to content or date. There was also a container of chopped garlic not tabled as to content or date. Additionally there was a large container of mashed potatoes which were dated 6/5 which were beyond the 7 day expiration date. The FSD confirmed, in interview on 6/13/16 at 1:30 PM, that the items should have been labeled or discarded.	R247	R247. At the time of the walk through, those items were disposed of. In-service of all kitchen staff on proper labelling and dating. Culinary Services Director or main Chef to complete daily inspection to ensure compliance. These audits will be documented and brought to the Communities QA Committee. Culinary Services Director responsible to ensure compliance.	7/19/16
R251 SS=E	VII. NUTRITION AND FOOD SERVICES	R251		

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R251	Continued From page 8 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: The facility failed to assure that all food and drink was stored so as to protect from all sources of contamination. Finding include: Per observation and staff interview there was a cake pan uncovered and containing flour and an open bag of brown sugar found resting on an open shelf in the baking area of the kitchen with other dry goods. In an interview on 6/13/16 at 1:30 PM the FSD (Food Service Director) confirmed that those items should have been in tightly sealed containers.	R251	R251. The brown sugar was sealed upon observation and the cake pan was immediately washed/sanitized. In-service all kitchen staff on proper storage of items including brown sugar. CSD or main Chef to monitor daily and document and bring to Community QA Committee to ensure compliance. CSD responsible to ensure compliance.	7/19/16
R253 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure that all food service equipment was kept clean. Findings include: Per observation, 6/13/16 at 1:30 PM on a tour of	R253	R253. Microwave was immediately cleaned. All vents and hoods cleaned upon observation during walkthrough. Daily inspection by CSD or main Chef to ensure cleaning schedules adhered to. Cleaning audits to be brought to Communities QA to ensure compliance. CSD responsible to ensure compliance.	7/19/16

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R253	Continued From page 9 the Main Kitchen there was a microwave oven on a shelf in the baking prep area of the kitchen that was visibly soiled both inside and out. There was also grease and dust noted on the removable filters in the range hood and on three intake vents directly opposite the cooking range. The FSD confirmed during the tour that there had been difficulty in maintaining the cleaning schedules. In an interview on 6/14/16 at 10:55 am the FSD provided printed cleaning schedules for the Serving Line, the Prep Line, Cold Kitchen Prep Line all to be done Daily and a General Weekly Cleaning List. The FSD stated during the interview that the tasks on the general cleaning lists were not specifically assigned but that staff did them "as we are able". He stated that the tasks, on all lists, are not tracked as to if or when they are completed.	R253		
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced	R302	R302. Fire Drills conducted for all shifts including evenings/nights, the week of June 14th 2016. Regulations reviewed with ED/Maintenance Director to ensure fire drills are completed during proper timeframes. Sign-in sheets for the drills to be brought to the Communities QA meetings to ensure compliance. Maintenance Director to ensure compliance.	7/19/16

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R302	Continued From page 10 by: Based on staff interview and record review, the facility failed to assure that fire drills were conducted at least quarterly and included the required times of the day, including morning, afternoon, evening and night times. Findings include: Per review of the fire drills conducted in the last 12 months, the facility failed to provide documentation of any drills during the 3rd quarter of 2015 (the period from 7/1/15/-/9/30/15). The facility also failed to conduct fire drills during the evening and night times during the last 12 month period. The failure to conduct the required fire drills was confirmed during interview with the Director of Maintenance.	R302		